Remarks/Arguments

Background

This Amendment is made in response to the Office Action dated August 5, 2008.

Claim Rejections – 35 U.S.C. § 101

In the Office Action, pending claims 1–21 were preliminarily rejected under 35 U.S.C. § 101 on the grounds that the claimed invention(s) were allegedly directed to non-statutory subject matter based on current caselaw interpretation of patentable subject matter under Section 101 of the Act, as presently interpreted by the Patent Office under *In re Bilski*. Specifically, the Patent Office has taken the position that process/method claims must be tied to a particular apparatus or must transform a physical object or material into a different state or thing.

Claim Rejections – 35 U.S.C. § 103

In the Office Action, claims 1-8 & 14-21 were preliminarily rejected under 35 U.S.C. § 103(a) as being allegedly unpatentable over *Little et al.* (U.S. Patent No. 5,350,509) in view of *Chapman et al.* (U.S. Patent No. 6,879,959) and in further view of *Provost et al.* (U.S. Patent No. 6,341,265) Further, in the Office Action, claims 9-13 were preliminarily rejected under 35 U.S.C. § 103(a) as being allegedly unpatentable over *Little et al.* (U.S. Patent No. 5,350,509) in view of *Chapman et al.* (U.S. Patent No. 6,879,959).

Discussion

In response to the Office Action, Applicant hereby cancels original claims 1-21 and submits new claims 22-44. New claims 22-44 include one independent claim (claim 22) that has been written specifically to overcome the Section 101 rejection, by explaining how the method claimed therein is tied to a specific and particular computer apparatus that is part of an intermediary claim management system, wherein the intermediary claim management system is in electronic communication between a practice management computer system of a respective medical service provider and a claims processing computer system of a respective medical insurance payer.

In addition, new independent claim 22 has been written to better focus the Examiner on the novelty and usefulness of at least one embodiment of the present invention and its use of the

intermediary claim management system that is designed and positioned between a conventional practice management computer system of a medical service provider and a conventional claims processing computer system of a medical insurance payer, whereby when the computer-implementable steps are performed, the quality of claims submitted by the medical service provider are improved and more likely to be approved for payment and whereby the approval is achieved more quickly due to the processes and steps performed by the particular computer apparatus of the intermediary claim management system.

It is respectfully submitted that the cited references do not teach, suggest, or obviate, alone or in combination, the method performed by the particular computer apparatus of independent claim 22 and, correspondingly, dependent claims 23-44 since the dependent claims merely add further limitations and details to the steps and structural components of independent claim 22.

Specifically, Little, which is the primary reference relied upon by the Patent Examiner, describes and teaches a health care payment adjudication and review system. The adjudication process and system taught by Little is from the point of view of the payer. Little describes a conventional claims processing computer system of a medical insurance payer. The present invention, and specifically the intermediary claim management system, is adapted to communicate with just such a payer system as described in Little. However, Little does not teach, describe or suggest the intermediary claim management system of the present invention or any of the process steps performed thereby. This is not surprising because payer systems are designed and configured to reject claims and to slow down approval and payment determinations. In contrast, the intermediary claim management system of the present invention and the process steps described herein are designed and configured to improve claims submitted for payment determinations, more quickly enable the medical service provider to update and correct a claim that has an identifiable error, and to speed up approval and payment determinations since claims are more likely to be in acceptable format by the time they are actually submitted to the claims processing system of the payer.

As expected, the adjudication system of Little determines whether a claim should be approved and, if so, how much payment should be made on the reimbursement claim. In

contrast, the intermediary claim management system of the present invention and the process steps described herein do not make such determinations – they are designed to access whether the claim is in proper and reviewable format for the payer system, to monitor the status of such claim, and to provide meaningful and understandable feedback, status, and report information to the medical provider who is seeking payment on the claim.

Chapman, which is also relied upon by the Patent Examiner, is also directed to and from the perspective of a payer system. Specifically, Chapman is directed and teaches a very narrow and targeted system for determining the value of a medical claim submitted to the system. In contrast, the intermediary claim management system of the present invention and the process steps described herein do not care about the value or determine an amount of payment that may be made by the payer. Rather, the present invention, as claimed in independent claim 22, is designed and configured to improve claims submissions and to speed up approval and payment determinations – it has nothing to do with determining or maximizing payment amounts.

The third reference cited by the Patent Examiner, Provost, is directed to a conventional practice management computer system of a medical service provider wherein the practice management computer system communicates directly and with numerous back and forth communications with the claim processing system of the payer. Again, this is a conventional arrangement that is described in the background of the present application and which the present invention is specifically designed to improve.

None of the three cited references alone or in combination with each other describe, teach, suggest or obviate a computer-implementable method for improving medical reimbursement claim processing between medical providers and insurance providers wherein an intermediary claim management system is in electronic communication between the practice management computer system of the respective provider and the claims processing computer system of the respective payer, wherein the intermediary claim management system includes a particular computer apparatus having software installed thereon, and wherein the software includes computer-executable instructions executable by the particular computer apparatus, wherein the method comprises the steps of receiving a medical reimbursement claim electronically from the practice management computer system of the respective provider, the

claim including data about a patient of the respective provider, a service provided to the patient by the respective provider, and the respective payer to whom the claim must be submitted for payment; determining if the claim received from the practice management computer system of the respective provider has any one of a plurality of identifiable errors; if the claim does not have any identifiable errors, formatting the claim into a format required by the claims processing computer system of the respective payer; submitting the claim electronically to the claims processing computer system of the respective payer for payment determination in the format required by the claims processing computer system of the respective payer; receiving a substantive response from the claims processing computer system of the respective payer regarding the claim; formatting the substantive response received from the claims processing computer system of the respective payer into a standardized format, wherein the standardized format is agnostic of the respective provider; and presenting the formatted, substantive response from the claims processing computer system of the respective payer to the respective provider to enable the respective provider to determine if further action on the claim is necessary.

Conclusion

The foregoing is presented as a full and complete response to the Office Action mailed August 8 2008, and is believed to have placed the newly presented claims 22-44 in condition for allowance. Such action is courteously solicited. If any issues remain that can be resolved by telephone, the examiner is respectfully requested to contact the undersigned at 404-504-5415.

Additionally, please note that the current Amendment includes 23 total claims and 1 independent claim. Because Applicant previously paid for 21 total claims and 3 independent claims, Applicant should owe additional fees for two total claims and zero additional independent claims. In addition, Applicant hereby requests and pays the appropriate fee for a three (3) month extension of time within which to file this response. If our assessment of additional claims fees or any other fees due is in error, please charge any fees that might be due or credit any overpayment to our Deposit Account No. 50-3537.

It is now believed that the application is in condition for allowance and such allowance is respectfully requested.

Respectfully submitted,

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February 5, 2009

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